TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Orthotexas Physicians and Surgeons

**Respondent Name**
Travelers Indemnity Co of Connecticut

**MFDR Tracking Number**
M4-16-1732-01

**Carrier's Austin Representative**
Box Number 5

**MFDR Date Received**
February 22, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per the clearing house report DOS 3/6/2015 was translated electronically on 3/12/2015 and accepted by the payer on 3/16/2015. All of these dates fall within the 95 day timely filing deadline."

**Amount in Dispute:** $571.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Had the Carrier acknowledged receipt of the bill electronically, part of that acknowledgement would have been the claim number. The claim number on the claim history, however, is blank, indicating it had not been received. Finally, the Carrier did not receive the billing until 12-07-2015 by facsimile submission of the bill. This received billing dated 03-30-2015, however, does not appear on the claim history submitted by the Provider."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 6, 2015 | 99213, 20611, J0702, J3490 | $571.00 | $279.09 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the requirements for claim submission for workers compensation claims.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. 28 Texas Administrative Code §134.1 sets out the guidelines for medical reimbursement
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - W3 – Additional payment made on appeal/reconsideration

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to the reimbursement guidelines?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.0272(b) provides that:

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   > (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
   > (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

   Documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. Namely, the requestor submitted a "Claim History" showing the "Service date of 03/06/2015" was "Payer Accepted 03/16/2015" and "Payer acknowledged receipt of the claim." The respondent states, Had the Carrier acknowledged receipt of the bill electronically, part of that acknowledgement would have been the claim number. The claim number on the claim history, however, is blank, indicating it had not been received." The Division finds insufficient evidence to support this statement therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. The services in dispute are for professional medical services. The applicable rule is 28 Texas Administrative Code §134.203 (c)(1) which states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   For codes 99213 and 20611 the maximum allowable reimbursement is calculated as follows:

   (DWC Conversion Factor/Medicare Conversion Factor) x Allowable = TX Fee MAR

   Code 20611 (56.2/35.7547) x $88.73 = $139.47
   Code 99213 (56.2/35.7547) x $69.57 = $110.12
   Total $249.59

28 Texas Administrative Code §134.203 (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS;

For code J0702 the following the MAR is calculated as (Fee schedule amount x 125%). Review of the January 2015 Medicare ASP Pricing File found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2015ASPFiles.html finds an allowable of $5.899. The MAR is (5.899 x 4 units = $23.60 x 125% = $29.50

3. The remaining code in dispute is J3490 – "Drugs unclassified injection." Review of the Medicare fee schedule finds no allowable listed. 28 Texas Administrative Code §134.203(f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

   28 Texas Administrative Code §134.1(e) states,
   Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
   (1) the Division's fee guidelines;
   (2) a negotiated contract; or
   (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section

   28 Texas Administrative Code §134.1 (f) states,
   Fair and reasonable reimbursement shall:
   (1) be consistent with the criteria of Labor Code §413.011;
   (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how reimbursement of $36.00 for code J3490 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $279.09.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $279.09 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | March , 2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.